SENATOR MARTIN M. LOONEY
PRESIDENT PRO TEMPORE

Eleventh District
New Haven, Hamden & North Haven

State of Connecticut
SENATE

State Capitol
Hartford, Connecticut 06106-1591
132 Fort Hale Road
New Haven, Connecticut 06512
Home: 203-468-8829
Capitol: 860-240-8600
Toll-free: 1-800-842-1420
www.SenatorLooney.cga.ct.gov

February 7, 2017

Senator Larson, Senator Kelly, Representative Scanlon and members of the Insurance and Real Estate Committee I would like to express my support for a number of bills on your agenda today

SB 19, AN ACT REQUIRING HEALTH INSURANCE COVERAGE OF A PRESCRIBED DRUG FOR A CHRONIC CONDITION DURING CERTAIN ADVERSE DETERMINATION REVIEWS and SB 25, AN ACT REQUIRING HEALTH INSURANCE COVERAGE OF A PRESCRIBED DRUG DURING THE ENTIRE ADVERSE DETERMINATION REVIEW AND EXTERNAL REVIEW PROCESSES address the situation in which a patient is prescribed a drug and the insurer defies the physician's order and determines that the drug is not medically necessary for the patient. These bills would require the insurer to cover the drugs during the course of the appeal. They would provide protection to patients with chronic disease during the course of either the entire appeal process (SB 25) or the insurers' internal grievance process (SB19). This legislation would assist patients in receiving appropriate care

that has been authorized by a patient's treating physician. It would also encourage the insurer to resolve the appeal with reasonable speed.

SB 25 includes the language that I proposed a couple of years ago which would require coverage during the entire course of the appeals process while SB 19 represents an agreement reached with the insurance carriers in 2014 but has not yet been passed by the General Assembly. Unfortunately, after agreeing to this language (and not testifying against it in committee or opposing it when it passed the Senate) it appears that the insurers opposed this language in the House last year and thus the bill was never called in the House. We should also make sure that the ACA's protections for concurrent reviews are included in Connecticut statute.

SB 20, AN ACT CONCERNING THE FACTORS TO BE CONSIDERED BY THE INSURANCE DEPARTMENT IN A HEALTH INSURANCE PREMIUM RATE FILING REVIEW, would add "affordability" to the criteria that the Department of Insurance should consider when approving or denying health insurance rates. Clearly, the affordability of the plan for consumers is of extraordinary importance when analyzing these rates.

SB 21 AN ACT CONCERNING HEALTH INSURANCE COVERAGE OF ORALLY AND INTRAVENOUSLY ADMINISTERED MEDICATIONS. would create greater equity in our healthcare system by extending to all patients the protections that we extended to cancer patients seven years ago. In 2010, the Connecticut General Assembly passed PA 10-63, AN ACT CONCERNING ORAL CHEMOTHERAPY TREATMENTS which addressed the fact that many current therapies can include oral rather than intravenous chemotherapy. Unfortunately, this act applied only to cancer

therapy and there are a number of other diseases that are now best treated with these types of medications. The oral medications can include biologics/biopharmaceuticals which have revolutionized care for some diseases and have offered many patients literally a new lease on life. However, these drugs are often extraordinarily expensive. Many of the drugs come in pill form and thus are covered as prescription drugs rather than as medical expenses. Many health plans would cover 100% of an IV infusion but only a percentage of a prescription drug. Thus, if the biologic/biopharmaceutical cost was $5000 per month and the patient had a plan that paid 80% of prescription drug costs, that patient would have to pay $12,000 per year out of pocket, while the out of pocket cost if the procedure was an IV infusion would be $0. This seems an absurd result since oral drugs would seem to save the healthcare system time as well as money. These new drugs are making many diseases manageable but it would appear that the practice of medicine, our healthcare system, and the insurance industry have not caught up with the power and convenience of these new drugs

SB 22 , AN ACT CONCERNING COST-SHARING FOR PRESCRIPTION DRUGS would cap the out of pocket costs of prescription drugs to $100 per drug per month. The average annual cost of a specialty pharmaceutical drug is higher than the national annual median income[1]. It is unfortunate that states cannot actually affect the prices of these drugs, but they can offer some financial relief for patients. This bill would certainly provide a meaningful incentive for insurers to do a better job negotiating with the pharmaceutical companies.

[1] https://www.washingtonpost.com/news/wonk/wp/2015/11/20/specialty-drugs-now-cost-more-than-most-household-incomes/

There are a number of other proposals to assist patients with prescription drug costs and policies including proposals to create a transparency website which would be a very important action for our state as well as proposals to require that a patient pay cost sharing off the negotiated price rather than the retail price and proposals to alter the reimbursement rate which would de-couple reimbursement for administration of the drug from reimbursement for the drug cost. I support all of those measures as well.

SB 23, AN ACT REQUIRING SITE-NEUTRAL PAYMENTS FOR HEALTH CARE SERVICES would require site neutral reimbursement policies. In 2015, SB 811 (PA 15-146) originally had contained a provision to create site neutral payment policies between physician owned practices and hospital owned outpatient practices. The site neutral reimbursement provision was ultimately removed in order to facilitate passage of the bill. The disparity in pricing for the same procedure at different sites of service goes beyond any rational explanation. One of the arguments used against including site neutral payment policies in that bill was that this policy had never been implemented anywhere. However, since then this policy has been included by Congress in the 2015 bipartisan budget deal[2]. The mechanism used by Congress is not ideal in that it is only prospective (it would apply to practices acquired after January 2017) and the payment rate for all is the lower physician rate. I would recommend that site neutral payment be implemented for all practices acquired after 2008 and I would suggest that the rate be slightly higher than the reimbursement for private physicians.

[2] (Section 603) that provides that effective January 1, 2017, Medicare payments for most items and services furnished at an off-campus department of a hospital that was not billing as a hospital service prior to the date of enactment will be made under the applicable non-hospital payment system

There are a variety of possible ways to set guidelines for that reimbursement rate and I would be happy to work with you on this matter. There are also a variety of ways to narrow the scope of this policy such as making it apply to only a subset of The Medicare Payment Advisory Commission (MEDPAC) recommendations (e.g. start with evaluation and management codes). I look forward to working with you to alleviate these site-driven disparities in healthcare costs. Not only can hospitals and hospital owned practices charge facility fees, they are also reimbursed at a much higher rate by insurers for the same procedures that independent physicians can provide. A good first step would be to have our state follow the MEDPAC recommendation for site neutral payments for MEDPAC's group 1 and 2 procedures. If the procedure or treatment can be done as safely in a physician's office, why should the physician not be reimbursed at the same rate as the hospital? There should not be two standards for a reasonable and customary cost. There are a variety of methods to create site neutral payment guidelines. One promising method would be to set a cap on the price at the Medicare rate plus a percentage (likely in the range of 150% of the Medicare rate). The entity in Massachusetts (The Group Insurance Commission) that covers state employees and retirees recently voted to cap payments to healthcare providers at 160% of Medicare.[3]

Clearly, there has been a movement toward consolidation in healthcare providers. Hospitals are merging with and acquiring other hospitals and thus creating large health systems. Hospitals and health systems are also purchasing physicians' practices. These larger entities make a number of claims, of which the accuracy

[3] https://www.bostonglobe.com/business/2017/01/23/state-health-care-giant-pushes-for-cuts-hospital-payments/wjLoSDShdpqTH4eQja0R1N/story.html

remains to be determined. First, they claim, "the Affordable Care Act made me do it." In truth, the ACA encourages cooperation and collaboration in order to achieve higher quality and lower cost care. The ACA encourages all the physicians who provide service to a specific patient to share information. The act does not demand consolidation and the movement toward consolidation long predates the ACA's passage. Second, these entities claim that consolidation will provide lower costs; however numerous studies have shown that in fact when physicians' practices are owned by hospitals and health systems the prices increase dramatically. It is also obvious that when hospitals are allowed to consolidate in a manner that creates a virtual monopoly, prices skyrocket. These large entities also claim they will provide higher quality care but they can provide no supporting evidence.

There are certainly smaller hospitals and health systems that are embracing integrated care using affiliation and cooperation with community physicians. These hospitals and community providers tend to offer the high quality and low cost services that our state should actively support.

SB 24, AN ACT REDUCING THE TIME FRAMES FOR URGENT CARE ADVERSE DETERMINATION REVIEW REQUESTS and HB 5270
AN ACT DECREASING THE TIME FRAMES FOR URGENT CARE ADVERSE DETERMINATION REVIEW REQUESTS would decrease the timeframe for expedited reviews; this time frame was unfortunately lengthened in PA 11-58. I am glad that this effort is bipartisan and I truly appreciate working with Representative Yaccarino on this issue. Under the current system, the insurer has 72 hours to respond to an urgent care request; in some cases 72 hours can put a patient in serious danger of a negative

outcome. I have in past years proposed and still prefer a 24 hour timeframe which is the current requirement for mental health urgent care requests. Last week the American Medical Association and the American Hospital Association announced joint policy goals[4] which included a 24 hour time frame for urgent care requests. Clearly 24 hours represents a superior policy, however, even 48 hours would be a significant improvement from current state law.

SB 426, AN ACT PROTECTING PATIENTS FROM INAPPROPRIATE BILLING PRACTICES, is a bipartisan joint proposal with Senator Fasano which would strengthen the protections from surprise billing that were included in PA 15-146. That act (which has been a model for other states) reformed many aspects of our healthcare system but as is often true, once enacted legislation may require small adjustments. This bill would ensure that when a patient receives care at an in-network hospital the patient would be responsible only for the in-network cost sharing from all providers who cared for that patient at that hospital. It appears that there are certain specialties and services that often are out of network in certain insurance plans at some hospitals. This legislation would ensure that services such as labs, radiology, and anesthesiology are included in the prohibition from surprise billing. Patients who choose to receive care at in-network hospitals should not be required to research which providers and services at those hospitals are in-network (if that information is even readily available). There are also proposals (I have a proposed bill in Public Health and there are proposals in other states) to simply require that in order for a hospital to credential a physician, that physician would be required to accept all the insurance that is accepted by the hospital. It is my hope that SB 426 will achieve the

[4] https://www.ama-assn.org/health-care-coalition-calls-prior-authorization-reform

same patient protections in a manner that is easier to implement. This bill is also a placeholder for other minor updates needed to PA 15-146.

SB 489, AN ACT ESTABLISHING STATE MEDICAL LOSS RATIOS FOR INDIVIDUAL HEALTH INSURANCE POLICIES AND GROUP HEALTH INSURANCE POLICIES ISSUED TO A SMALL EMPLOYER would incorporate Medical Loss Ratios (MLR) into Connecticut state statutes. The Affordable Care Act (ACA) sets Medical Loss Ratios for insurers which limit the amount of money that insurance companies can spend on administrative costs and ensures that the majority of the dollars be spent on actual medical care. With the current threats to the Affordable Care Act I believe it would be prudent to codify the ACA's MLR into Connecticut's statutes which is what SB 489 would do.

Thank you for hearing these extraordinarily important bills.